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8 **BEFORE THE**  
9 **BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2013-6246

13 **ROXANNE CAMPBELL**  
21 Wekiva Pointe Circle  
Apopka, FL 32712

**A C C U S A T I O N**

14 **Registered Nurse License No. 768882**

15 Respondent.

16  
17 Louise R. Bailey, M.Ed., RN ("Complainant") alleges:

18 **PARTIES**

19 1. Complainant brings this Accusation solely in her official capacity as the Executive  
20 Officer of the Board of Registered Nursing ("Board") Department of Consumer Affairs.

21 2. On or about February 23, 2010, the Board issued Registered Nurse License Number  
22 768882 to Roxanne Campbell ("Respondent"). The license was in full force and effect at all  
23 times relevant to the charges brought herein and will expire on November 30, 2013, unless  
24 renewed.

25 **JURISDICTION**

26 3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that  
27 the Board may discipline any licensee, including a licensee holding a temporary or an inactive  
28

1 license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing  
2 Practice Act.

3 4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not  
4 deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or  
5 to render a decision imposing discipline on the license.

### 6 **STATUTORY PROVISIONS**

7 5. Code section 2761 states, in pertinent part:

8 "The board may take disciplinary action against a certified or licensed nurse or deny an  
9 application for a certificate or license for the following:

10 (a) Unprofessional conduct...

11 (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action  
12 against a health care professional license or certificate by another state or territory of the United  
13 States, by any other government agency, or by another California health care professional  
14 licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that  
15 action."

### 16 **COST RECOVERY**

17 6. Code section 125.3 provides, in pertinent part, that the Board may request the  
18 administrative law judge to direct a licentiate found to have committed a violation or violations of  
19 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
20 enforcement of the case.

### 21 **FIRST CAUSE FOR DISCIPLINE**

#### 22 **(Out-of-State Discipline)**

23 7. Respondent is subject to discipline under Code section 2761(a)(4), in that effective  
24 January 5, 2011, pursuant to a Final Order, attached hereto as **Exhibit A**, issued by the State of  
25 Florida Board of Nursing in a disciplinary proceeding titled, *Department of Health vs. Roxanne*  
26 *Campbell, Case No. 2010-04063, License No. RN 3173622*, Respondent was reprimanded,  
27 assessed an administrative fine, required to complete educational courses, and placed on  
28 probation for a period of one (1) year with terms and conditions. The Final Order was based on

Findings of Fact, including the following: While employed as a registered nurse at Hospice of the Comforter, located in Altamonte Springs, Florida, and caring for patient R.L., Respondent failed to do the following: 1) Review the patient's records before administering medication to the patient; 2) Administered medication to the patient when that order had been discontinued; 3) Administered the wrong medication to the patient; 4) Administered oral medication to the patient by IV; and 5) Failed to properly document the administration of the medications.

**PRAYER**

**WHEREFORE**, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 768882, issued to Roxanne Campbell;
2. Ordering Roxanne Campbell to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,
3. Taking such other and further action as deemed necessary and proper.

DATED: February 19, 2013 *for* Stacie Ben  
LOUISE R. BAILEY, M.ED., RN  
Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
Complainant

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## EXHIBIT A



Rick Scott  
Governor

H. Frank Farmer, Jr., M.D., Ph.D. FACP.  
State Surgeon General

CERTIFICATION

I, Angela Barton, Deputy Agency Clerk and Custodian of Records, HEREBY certify the following to be true and correct as on file with the Department of Health.

Attached is a true and correct copy of a **Final Order from Case Number 2010-04063**, as maintained by the Department of Health. The attached is a regularly received and retained record of the **Board of Nursing vs Roxanne Campbell; RN3173622** and is received and retained in the ordinary course of business of the Department of Health.

Angela Barton  
Deputy Agency Clerk

STATE OF FLORIDA  
COUNTY OF LEON

Before me, personally appeared Angela Barton whose identity is personally known to me as Deputy Agency Clerk, and who, acknowledges that his/her signature appears above.

Sworn and subscribed to, before me, this 29th day of December 2011.

  
Notary Public-State of Florida

Type or Print Name

STATE OF FLORIDA  
BOARD OF NURSING

By: Angela Sanders  
Deputy Agency Clerk

DEPARTMENT OF HEALTH,

Petitioner,

vs.

Case No.: 2010-04063  
License No.: RN 3173622

ROXANNE CAMPBELL,

Respondent.

**FINAL ORDER**

This matter appeared before the Board of Nursing at a duly-noticed public meeting on December 2, 2010 in Miami, Florida, for a hearing not involving disputed issues of material fact pursuant to Respondent's Election of Rights requesting a hearing pursuant to Sections 120.569 and 120.57(2), Florida Statutes. Petitioner has filed an Administrative Complaint seeking disciplinary action against the license. A copy of the Administrative Complaint is attached to and made a part of this Final Order. Petitioner was represented by William Miller, Assistant General Counsel, Florida Department of Health. Respondent was not present.

**FINDINGS OF FACT**

Therefore, the Board adopts as its finding of facts the facts set forth in the Administrative Complaint.

**CONCLUSIONS OF LAW**

Based upon the Findings of Fact, the Board concludes the licensee has violated Section 464.018(1)(h), (n), Florida

Statutes.

The Board is empowered by Sections 464.018(2) and 456.072(2), Florida Statutes, to impose a penalty against the licensee. Therefore it is ORDERED that:

The license of ROXANNE CAMPBELL is hereby REPRIMANDED.

The licensee must pay an administrative fine of \$250.00 and investigative costs of \$2,277.62 within 36 months of the date this Final Order is filed. Payment shall be made to the Board of Nursing and mailed to, DOH-Compliance Management Unit, Bin C76, P.O. Box 6320, Tallahassee, Florida 32314-6320, Attention: Nursing Compliance Officer.

The licensee shall enroll in and successfully complete courses in Medication Administration (16 hr) and Pharmacology (40 hr). This shall be in addition to other normally required continuing education courses. Verification of course content and course completion must be submitted to the Nursing Compliance Officer within six (6) months from the date of this Order. The Board will retain jurisdiction for the purpose of enforcing continuing education requirements.

The license of ROXANNE CAMPBELL is placed on probation for 1 year, subject to the following conditions:

The licensee shall not violate chapters 456 or 464, Florida Statutes, the rules promulgated pursuant thereto, any other state or federal law, rule, or regulation relating to the practice or

the ability to practice nursing.

The licensee must report any change in address or telephone number, employment, employer's address or telephone number, or any arrests, in writing within 10 working days to the Nursing Compliance Officer at the Department of Health, Client Services Unit, HMQAMS, BIN # C01, 4052 Bald Cypress Way, Tallahassee, Florida 32399-3251.

Whether employed as a nurse or not, the licensee shall submit written reports to the Nursing Compliance Officer which shall contain the licensee's name, license number, and current address; the name, address, and phone number of each current employer; and a statement by the licensee describing her employment. This report shall be submitted to the Nursing Compliance Officer every three (3) months in a manner as directed by the Nursing Compliance Officer.

The licensee must work in a setting under direct supervision and only on a regularly assigned unit. Direct supervision requires another nurse to be working on the same unit as the licensee and readily available to provide assistance and intervention. The licensee cannot be employed by a nurse registry, temporary nurse employment agency or home health agency. Multiple employers are prohibited. The licensee cannot be self-employed as a nurse.

All current and future settings in which the licensee



practices nursing shall be promptly informed of the licensee's probationary status. Within five days of the receipt of this Order, the licensee shall furnish a copy to her nursing supervisor. The supervisor must acknowledge this probation to the Nursing Compliance Officer in writing on employer letterhead within ten days. Should the licensee change employers, she must supply a copy of this Order to her new nursing supervisor within five days. The new employer shall acknowledge probation in writing on employer letterhead to the Nursing Compliance Officer within ten days. The licensee shall be responsible for assuring that reports from nursing supervisors will be furnished to the Nursing Compliance Officer every three (3) months. That report shall describe the licensee's work assignment, work load, level of performance, and any problems. Any report indicating an unprofessional level of performance shall be a violation of probation.

If the licensee leaves Florida for thirty (30) days or more or ceases to practice nursing in the state, this probation shall be tolled until the licensee returns to the active practice of nursing in Florida. Then the probationary period will resume. Unless this Order states otherwise, any fines imposed or continuing education required must be paid or completed within the time specified and are not tolled by this provision. Employer reports are not required during the time probation is tolled.

Working in nursing without notification to the Board is a violation of this Order.

The licensee's failure to comply with the terms of this Probation Order without the prior written consent of the Board shall be a violation of this Probation. The probation shall not be terminated until the licensee has complied with all terms of probation. The failure to comply with the terms of probation set forth above shall result in a subsequent Uniform Complaint Form being filed by the Board with the Department of Health against the Respondent's license, which may result in additional administrative fines, probationary periods, and/or suspensions being imposed against the Respondent's license. The licensee shall pay all costs necessary to comply with the terms of this Order. Such costs include, but are not limited to, the cost of preparation of investigative and probationary reports detailing the compliance with this probation; the cost of obtaining, and analysis of, any blood or urine specimens submitted pursuant to this Order; and administrative costs directly associated with the licensee's probation.

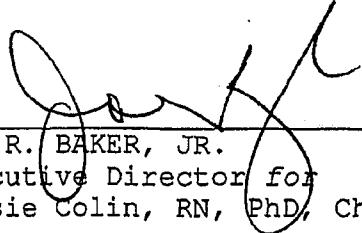
The terms of this Order are effective as of the date this Order is filed with the clerk for the Department of Health. The Board office will send the licensee information regarding probationary terms, however, failure of the licensee to receive such information DOES NOT EXCUSE COMPLIANCE with the terms of

this Order.

This Final Order shall become effective upon filing with the Clerk of the Department of Health.

DONE AND ORDERED this 4<sup>th</sup> day of Jan, 2011.

BOARD OF NURSING

  
JOE R. BAKER, JR.  
Executive Director for  
Jessie Colin, RN, PhD, Chair

**NOTICE OF APPEAL RIGHTS**

Pursuant to Section 120.569, Florida Statutes, the parties are hereby notified that they may appeal this Final Order by filing one copy of a notice of appeal with the clerk of the department and by filing a filing fee and one copy of a notice of appeal with the District Court of Appeal within thirty days of the date this Final Order is filed.

**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Mail to **ROXANNE CAMPBELL**, 21 Wekiva Pointe Circle, Apopka, FL 32712 and by interoffice mail to **Lee Ann Gustafson**, Assistant Attorney General, PL-01, The Capitol, Tallahassee, Florida 32399-1050; and **William Miller**, Assistant General Counsel, Department of Health, 4052 Bald Cypress Way, Bin # C-65, Tallahassee, Florida 32399-3265 on this

5<sup>th</sup> day of January, 2011.

Angelo Sanders

**Deputy Agency Clerk**

**STATE OF FLORIDA  
DEPARTMENT OF HEALTH**

**DEPARTMENT OF HEALTH,**

**Petitioner,**

**Case No. 2010-04063**

**v.**

**ROXANNE CAMPBELL, R.N.,**

**Respondent.**

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**ADMINISTRATIVE COMPLAINT**

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Nursing against Respondent, Roxanne Campbell, R.N., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of nursing pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 464, Florida Statutes.

2. At all times material to this Complaint, Respondent was a registered nurse (R.N.) within the state of Florida, having been issued license number RN 3173622.

3. Respondent's address of record is 21 Wekiva Pointe Circle, Apopka, Florida 32712.

4. At all times material to this Complaint, Respondent was employed as a RN by Hospice of the Comforter (HOTC), in Altamonte Springs, Florida, a corporation which provides nursing services on a contract basis for hospice patients.

5. On or about February 18, 2010, Respondent was assigned to provide nursing services at the home of Patient L.R. during the night shift.

6. At all times material to this Complaint, Patient L.R. was a 45 year-old patient diagnosed with: end stage metastatic neoplasm disease, along with other medical disorders.

7. Patient R.L.'s treating physician prescribed Ativan in a concentration of two (2) milligrams (mg) per milliliter (ml) with a dose of 0.5 mg to 1.0 mg via I.V. port every four (4) hours to treat Patient R.L.'s anxiety, nausea, and/or spasms.

8. Ativan is the brand name for lorazepam and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, lorazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted

medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

9. Patient R.L.'s treating physician prescribed oral Ativan in a concentration of two (2) mg/ml with a dose of 1.0 mg every six (6) hours.

10. Oral Ativan is a liquid medication which is administered by mouth or through a percutaneous endogastric gastronomy (PEG) tube (feeding tube), but is not sterile, and is not compounded for I.V. use. Oral Ativan is not administered via I.V. port because of the risk of infection.

11. At approximately 11:00 a.m. on February 18, 2010, Patient R.L.'s treating physician ordered that the administration of the oral Ativan be discontinued.

12. On or about February 18, 2010, the HOTC day shift nurse documented in Patient R.L.'s medication administration record (MAR) that Patient R.L.'s order for oral Ativan was discontinued.

13. At approximately 8:00 p.m. on February 18, 2010, Respondent and the HOTC day shift nurse documented in Patient R.L.'s crisis care controlled substance log that she and the HOTC day shift nurse counted approximately 5.75 ml of intravenous Ativan was available for Patient R.L.

14. At approximately 12:00 a.m. on February 19, 2010, Respondent made an entry in Patient R.L.'s MAR that she administered two (2) mg/ml concentration of Ativan via I.V. port to Patient R.L. without specifying the Ativan dosage she administered to the patient.

15. Respondent did not read the bottle of Ativan before she administered the medication to Patient R.L. at approximately 12:00 a.m. on February 19, 2010.

16. At approximately 4:00 a.m. on February 19, 2010, Respondent made an entry in Patient R.L.'s MAR that she administered two (2) mg/ml concentration of Ativan via I.V. port to treat Patient R.L.'s anxiety, nausea, and/or spasms without specifying the Ativan dosage she administered to the patient.

17. Respondent did not read the bottle of Ativan before she administered the medication to Patient R.L. at approximately 4:00 a.m. on February 19, 2010.

18. At approximately 8:00 a.m. on February 19, 2010, Respondent documented in Patient R.L.'s MAR that she administered two (2) mg/ml concentration of Ativan via I.V. to Patient R.L. to treat his anxiety, nausea,



and/or spasms without specifying the Ativan dosage she administered to the patient.

19. Respondent did not read the bottle of Ativan before she administered the medication to Patient R.L. at approximately 8:00 a.m. on February 19, 2010.

20. At approximately 8:00 a.m. on February 19, 2010, Respondent and the HOTC day shift nurse documented in Patient R.L.'s crisis care controlled substance log that she and the HOTC day shift nurse counted approximately 4.50 ml of intravenous Ativan was available for Patient R.L.

21. At approximately 12:00 a.m. on February 19, 2010, Respondent administered approximately two (2) mg/ml of liquid Ativan via I.V. to Patient R.L., contrary to orders from Patient R.L.'s treating physician.

22. At approximately 4:00 a.m. on February 19, 2010, Respondent administered two (2) mg/ml concentration of oral Ativan of an unknown dosage, via I.V. port to Patient R.L., contrary to orders from Patient R.L.'s treating physician.

23. At approximately 8:00 a.m. on February 19, 2010, Respondent administered two (2) mg/ml concentration of oral Ativan of an unknown

dosage, via I.V. port to Patient R.L., contrary to orders from Patient R.L.'s treating physician.

24. On or about February 19, 2010, Patient R.L.'s treating physician was notified of the patient's condition and Patient R.L.'s treating physician visited the patient at the patient's home for further evaluation and treatment.

### **COUNT ONE**

25. Petitioner realleges and incorporates paragraphs one (1) through twenty-four (24) as if fully set forth herein.

26. Section 464.018(1)(n), Florida Statutes (2009), provides that failure to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the licensee is not qualified to by training or experience, constitutes grounds for discipline.

27. Respondent failed to meet the minimal standards of acceptable and prevailing nursing practice in her care of Patient L.R. in one or more of the following ways:

- a) by failing review the patient's medical records before administering medication to the patient; and/or

- b) by failing to read the patient's medication bottle before administering the medication to the patient; and/or
- c) by administering a medication which the patient's treating physician had ordered should no longer be administered to the patient; and/or
- d) by administering the wrong medication to the patient; and/or
- e) by administering oral Ativan to the patient via an I.V. port.

28. Based on the foregoing, Respondent violated Section 464.018(1)(n), Florida Statutes (2009), by failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the licensee is not qualified by training or experience.

**COUNT TWO**

29. Petitioner realleges and incorporates paragraphs one (1) through twenty-four (24) as if fully set forth herein.

30. Section 464.018(1)(h), Florida Statutes (2009), provides that unprofessional conduct, as defined by Board rule, constitutes grounds for discipline by the Board of Nursing.

31. Rule 64B9-8-005(1), Florida Administrative Code, provides that unprofessional conduct includes inaccurate recording.

32. Respondent engaged in acts of inaccurate recording in one or more of the following ways:

a) by failing to document in Patient R.L.'s MAR on February 19, 2010, the specific dosage of the two (2) mg/ml concentration of Ativan via I.V. port she administered to Patient R.L. at approximately 12:00 a.m., 4:00 a.m., and 8:00 a.m. on February 19, 2010; and/or

b) by failing to document in Patient R.L.'s MAR on or about February 19, 2010 that she administered two (2) mg/ml concentration of oral Ativan via I.V. to Patient R.L. at approximately 12:00 a.m., 4:00 a.m., and 8:00 a.m. on February 19, 2010; and/or

c) by documenting in Patient R.L.'s crisis care control log that Patient R.L.'s intravenous Ativan decreased from 5.75 ml

to 4.50 ml at approximately 8:00 a.m. on February 19, 2010,  
when the medication had not been administered and/or  
wasted.

33. Based on the foregoing, Respondent violated Section 464.018(1)(h), Florida Statutes (2009), by engaging in unprofessional conduct as defined by Rule 64B9-8.005(1), Florida Administrative Code, to include inaccurate recording.

WHEREFORE, the Petitioner respectfully requests that the Board of Nursing enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 16<sup>th</sup> day of September, 2010.

Ana M. Viamonte Ros, M.D., M.P.H.  
State Surgeon General

**FILED**

DEPARTMENT OF HEALTH  
DEPUTY CLERK

CLERK: Roxanne May

DATE 9-17-10

Annette Miller

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